MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Library of Congress
Madison Building
6th Floor, West Dining Room
Washington, D.C.

Wednesday, June 16, 1999
9:44 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
BEA BRAUN, M.D.
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
HUGH W. LONG, Ph.D.
FLOYD D. LOOP, M.D.
WILLIAM A. MacBAIN
JANET G. NEWPORT
CAROL RAPHAEL
ALICE ROSENBLATT
GERALD M. SHEA
MARY K. WAKEFIELD, Ph.D.

P R O C E E D I N G S

DR. WILENSKY: We're going to start. This is our first meeting, abbreviated though it is, when we have new commissioners present. I want to take an opportunity to publicly welcome them. Maybe they can just put their hands up as I mention their names; Carol Raphael, Floyd Loop, Mary Wakefield, and Bea Braun. We're delighted to have you as part of the MedPAC group.

As people in the audience may know, this is a meeting which we did last year as well, although there had not been very much of a history of having these types of meetings.

What we want to do is just briefly go through and talk about some of the areas that we are planning to focus on in our work for the coming year starting in September. It is a preliminary cut based on discussion of work that we are obligated to do because of statute, or which is ongoing. But we use a day or a day and-a-half period in June to talk about some of the issues that we would like to give higher priority to, to the extent that we can, during the course of the year.

I think we all understand, particularly people who have experienced this process before, that whatever our plans or thoughts for a work agenda, it will be subject to change depending on what happens in the Congress. We are here as an advisory commission to the Congress and to the extent that issues change, and that makes us believe we ought to change our focus, or to the extent that Congress specifically asks us to look at issues, we will make some modifications in the work plan as we go along during the year.

When we meet in June it gives the commissioners a period to talk about some of the issues they would particularly like to see pursued, and to do so outside of the normal crush of work that goes on in each of the regular sessions that we have during the year. And we thought it appropriate to share with you the areas in which we were planning to give some additional work, at least as of now.

I'm going to have some summary discussion to indicate the areas where we had designated priority section. I'm going to see whether the staff who have been involved, if they're here, can help review the bidding, so to speak, in terms of where we had regarded the issues of priority because of statute or because of ongoing work. It is, of course, a time that I'd like some of the commissioners to indicate their views about why they think these areas are particularly important or why we need to focus in some areas rather than others.

The other thing that we would like to share with you, because we continue to have some discussion primarily in terms of bringing our new members up to speed on the conversations that had gone on during the year, and continuing some of the consideration of the options at hand, is our discussion on graduate medical education. We are not quite at the point yet where we are making firm recommendations.

There will be a meeting in July, I believe July 15th, which will be a recommendations meeting. But we thought it was also important to share some of the discussion that went on bringing our new commissioners up to the issues that we had considered during the last few sessions where our views have begun to crystallize on graduate medical education. Again, this is a meeting in which any changes in thinking that you wish to raise or that come about from this meeting is, obviously, now part of what will go forward and into our July session where we will make some, I hope, final recommendations in order to meet our August deadline.

I'm going to go through just some -- I'm not sure we'll go through all of them because I do want to make sure that we have time for graduate medical education. But I'd like to talk about some of the major areas that we focused on yesterday. Let me turn to the summary page on Medicare+Choice for the commissioners, if you have your notebooks with you, to talk about some of these issues.

DR. ROSS: Let me just take a moment to discuss briefly the broad organization of our work on Medicare+Choice and then give commissioners a chance to comment or reiterate the kinds of things we talked about.

We brought basically a group of topics to the commissioners for consideration and the three that I think caught the attention of the group at a broad level, a major heading level, if you will, are issues pertaining to base payment rates, issues pertaining to risk selection and risk adjustment, and issues pertaining to plan participation, benefits, and enrollment changes.

Under the base payment rates, I guess the general organizing theme that we have tried to look at is to try and get an idea of payment adequacy and payment rates in different areas, and to look at what's going on with the changes we now have where we have a situation that a number of counties are at the floor, some are now in the blend, some are in the minimum update range, and we're starting to get trends where there's a divergence between Plus-Choice payment rates and fee-for-service spending. We want to look at that.

We want to monitor what's happening, see if we can link it to participation by plans and look at enrollment by beneficiaries. We're interested also in looking at the variation in fee-for-service spending across counties and to see how that compares and how that feeds into the differences that we're seeing with the Plus-Choice payment rates.

Laid over top of this, of course, is the risk selection proposal that HCFA has announced affecting rates beginning January 1. Of course, that's going to be phased in, 10 percent in the first year, 30 percent in the second year, and rising thereafter. We hope to do additional work to look at the impacts of that risk adjustment, to work with encounter data from plans and try and get a better sense of what the impacts will be, and of course, to monitor as it's going on in the field.

I guess additionally we will monitoring and analyzing developments as they occur overall. Obviously, the next important date for Medicare+Choice plans is July 1st with the filing of the benefit and premium packages. We'll be looking closely at that to see what happens in terms of plan participation. Are there withdrawals, as many have claimed there will be a significant number of withdrawals? We will see when the first -- we won't see on July 1st but I hope we will see shortly thereafter, and try and get a sense of what's going on with that.

Is it happening in particular geographic areas? Is it more widely dispersed? And try and get a sense, as we did last year, of is there as story you can tell about why it's occurring?

Last year we noted in our report that we thought that the plan withdrawals were not solely related to changes in payment rates but in fact reflected a whole lot of other developments that were going on, including what was happening with plans' commercial lines of business. We will have to do a similar kind of assessment this year as the Plus-Choice program begins to get rolled out.

I don't know that I want to go into specifics. I'll just stop there.

DR. WILENSKY: That's fine. There are two areas specifically I thought I would mention. Again, if any of the commissioners want to comment either on research plans that we talked about or ideas that you may have had since yesterday or Monday as we raise some of these issues.

As Murray indicated, we're particularly interested in monitoring any change that continues to occur with plan availability and enrollment and disenrollment. So we are going to be doing some analysis of looking at the relationships of disenrollment and enrollment with various factors, including some of the information that's available from the CAHPS disenrollment service looking at consumer satisfaction as an issue, and obviously looking at the obvious financial relationships as they exist.

There is a recently-completed GAO report that looked at disenrollment as of last year -- 1998 disenrollment -- and commented or attempted to assess how much of the disenrollment is attributable to financial factors that are part of the Medicare program or part of business relationships, and also assess something about the number of new entrants. This clearly remains a very important issue for the seniors and for the Congress, and it's within those type of activities that we plan to focus attention.

However, we've also indicated an interest looking at the base payment level and going back to review some of the work ProPAC had done several years earlier looking at different spending in fee-for-service Medicare and to see whether or not we can reasonably make some updates in that analysis. A lot of what is going on now is a reflection of base payment changes throughout the country in terms of the underlying traditional Medicare payment subject to the various floors and caps. So doing some analysis on those base variation payments is important.

ProPAC had done some very interesting work three or four years ago and we've asked Julian and others who have been involved in that activity if they can go back and see whether or not it may be possible to take another look now several years later. So it's an important supplementary issue that was raised in the whole discussion of setting Medicare+Choice rates.

DR. LONG: I just wanted to mention that in addition to plan participation, to the extent possible we also wanted to monitor changes in benefit packages.

DR. WILENSKY: Janet?

MS. NEWPORT: Just a general statement. I think that the scope of work is the right direction, and I think now that we have the ability to measure what the impact of the Balanced Budget Act is in operational terms as opposed to theoretical terms that this will be an important area of study for the Commission.

DR. WILENSKY: I neglected, in going around to introduce our new commissioners, to indicate that we also have a new deputy director. I'd like to make sure everyone knows that Lu Zawistowich is with us now as a deputy director. Many of you know her from her previous roles at the Health Care Financing Administration, as do I from that role. So welcome to this meeting.

Any other comments that people want to raise with regard to some of the issues on Medicare+Choice?

We had talked about looking at some issues with regard to base payment rates for the PACE program. I think that's raised a more general issue of trying to have some focus on dual eligibility rather than focusing strictly on PACE per se, or even PACE and Evercare and social HMOs. We'll, as we go through the course of the summer, try to see whether it will be possible for us to give a focus on this issue which we have not been doing in our past two reports, or at least not to the extent that the predecessor commissions had done.

As I've said, what happens after we have a session where we lay out our wish list of all the things we would like staff to look at during the next work year is some hard, cold reality setting in to assess what we'd like and what we're likely to be able to do, especially if we are going to leave some amount of resources aside for unintended or unanticipated requests that will come up during the year. But that's an area that commissioners as a whole had raised as one of real importance to them.

If there are no further questions or further comments with regard to Medicare+Choice I'm going to turn to the Part B services workplan. Kevin, if you can come join us, pull up a next chair near Judy or Alice.

We also appreciate the forbearance of our guests, our public attendees in terms of finding us and dealing with both a smaller room and the unavailability of microphones. We had thought to have this session down on Capitol Hill but obviously had some trouble securing the room that we thought we had set aside for this meeting. So we'll just ask you to make do as we will.

Kevin, do you want to review the issues as best you can in terms of the areas of focus and priority that we came up with, particularly the blend of those things that we have to do by statutory directive and those that we've indicated an interest in pursuing?

MR. HAYES: Sure. We approached Part B services, as you might expect, recognizing that we're talking here about a range of services that includes physician services as well as those services provided in hospital outpatient departments, ambulatory surgical centers. This category of services also includes durable medical equipment, payment for outpatient dialysis services, ambulance services, and so on.

We took into consideration the work that had been done by this commission so far in these different areas as well as work that had been conducted by the predecessor commissions. We also recognized that others, like the General Accounting Office, and so on had addressed a number of issues in these areas. We settled upon several priorities for the coming year as far as the Commission's work goes, work that would be done in preparation for putting together the Commission's March 2000 report.

I think I have fairly complete notes about the priorities that were discussed by the Commission, but if others have more detailed information that I have, please speak up.

One area that we want to pay attention to has to do with the idea of payment policy consistency. We recognize that payment rates for similar services provided in different sites, physicians' offices, hospital outpatient departments, and ambulatory surgical centers, differ already, kind of at baseline I guess we might say. We also recognize that the mechanisms for updating those payment rates differ as well.

So we'd be looking at different ways to try and bring about some more consistency in Medicare's payment policy to avoid creation of incentives that might otherwise guide the delivery of care in favor of one setting versus another.

We also anticipate in the area of physician payment policy that we will be seeing proposals from the Health Care Financing Administration in the near future on payments for physicians' professional liability expenses, so we have in mind some work there to prepare for review and preparation of comments on HCFA's proposal.

Other work with respect to physician payment policy will be conducted as part of our normal course of operations. We'll be monitoring changes in physician payment rates and use of services to help inform the Commission about making recommendations with respect to the sustainable growth rate system that is used to update physician payment rates.

Scanning over the list here, we also will continue to do the work we've been doing with respect to hospital outpatient departments and monitoring HCFA's efforts to implement a prospective payment system in that area. We also want to continue the work that the Commission has started with respect to outpatient dialysis services and explore alternatives to the composite rate that's currently used to pay dialysis facilities.

Other work, of course, will continue in the area of ambulatory surgical centers, and that's pretty much it I think. Does that pretty much summarize it?

DR. WILENSKY: Yes. Any comments that people would like to make about areas either that you think that we are not covering adequately or would like to talk about issues that were of particular concern to you in this area?

With the possible exception of the outpatient dialysis where we've been trying to put additional effort, this really, I think, has followed pretty much our past strategies of responding to the issues as reflected in the relative value scale changes as they've been introduced. So making sure that we discuss issues with regard to the practice expense and with regard to the professional liability, the sustainable growth rate issues that we've had with regard to that growth rate.

We did give a little bit of time, and if the opportunity arises we can share, an issue that we raised last year when we had our public meeting. That is some concern about the fact that the different ways that we go about making updates in the physician area vis-a-vis what we do in the hospital sector.

Maybe, Jack, when we talk about hospitals you can raise some of the issues that we've talked about in terms of trying to look at these cross-cutting issues with the differences in the fundamental philosophy that is used for the hospital, which is more of a bottom-up, component by component assessment of appropriate factors for change leading to whatever that provides as a composite analysis versus what we do with regard to the Part B and particularly the physician sector where we make recommendations, but basically it's a top-down strategy in terms of the sustainable growth rate where it's tied to a growth rate, either GDP or GDP-related, rather than looking at the component factors and allowing them to go up.

So this is an issue that we've raised in the past. We had some more discussion yesterday about that.

DR. KEMPER: And the risk payment is a third one that takes still a different tack.

DR. WILENSKY: Any other issues you want to have raised?

Thank you.

An area that we talked about in some detail, because it was a very important part of our general mandate with regard to assessing any changes in access, but our particular emphasis during this last year's report on quality, was reflected in the discussions we've had on quality. Beth, why don't you review where we ended up in terms of the areas of focus?

MS. DOCTEUR: Staff put forward a number of proposed projects for research and analytic work relating to access and quality. Most of this work would be geared toward our June report to Congress in the coming year. The proposed research agenda includes work both relating to program-wide issues and sector-specific issues, and I'll briefly review the projects that commissioners expressed the most interest in pursuing for the coming year.

The Commission is required to monitor access to care, specifically to report on the Secretary's report to Congress on access to care. Work that the Commission is interested in pursuing over the coming year will include evaluating barriers to access that are perceived by Medicare beneficiaries, using the Medicare current beneficiary survey.

We'll also be monitoring trends in use of services, to the extent that that can help us say something about evaluating access to care. And we'll be hoping to look at specific services and to move down from the aggregate level in hopes that that can help us understand access a little better.

Also very closely related to monitoring access to care will be the work on looking at beneficiaries' financial liability. The Commission will be evaluating trends in out-of-pocket spending and also examining options for reducing financial hardship in areas where hardships are found.

On the quality front, Commission has expressed some interest in continuing its work that it began this past year in looking at the quality of care for beneficiaries with end stage renal disease. Specifically, we'll be looking at the existing quality assurance system for dialysis care, and also assessing practice patterns for ESRD care, and evaluating the effect of Medicare's payment policies on technological innovation and change.

The Commission is interested in looking at quality of care at the end of life, again as it has done these past two years now. Work proposed for the coming year will include some empirical analysis to look at patterns of care.

The Commission's work on structuring and fostering informed beneficiary choice will continue this year. The plans at this point are to monitor the kickoff of a national Medicare education program which is scheduled to begin nationwide this fall, and also to analyze some data from the 1997 Medicare current beneficiary survey that looked at -- there was a special battery that looked at beneficiaries' knowledge and information needs.

The Commission will begin a new project this year to look at quality assurance and improvement for post-acute care. We'll begin with a literature review on what we know about the technical quality of care in various post-acute settings. We'll also review and assess various quality measurement, some of the new quality measurement systems and improvement systems that HCFA has developed, using the framework for analysis that we put forward in our June report to Congress this year.

Another new issue that the Commission is interested in pursuing is the question of health data and information systems that are needed to support Medicare program administration. The Commission plans to assess how Medicare's data reporting requirements might be made more effective and efficient to meet the diverse needs for various program administration functions, including quality assurance, but also payment and other types of functions.

Another area that we're interested in taking a look at this year is a question of enforcement of Medicare's quality standards and other types of program requirements. We plan to look at the survey process and also to explore issues relating to deemed status for plans, accredited providers and plans.

A couple of other areas that the Commission will be doing a little bit of work in are the quality improvement system for managed care. We'll continue to monitor implementation of that program, and also to keep an eye specifically on the issue whether or not QSMIC is adaptable to various types of plan structures, including PPOs, where those plans are interested in participating in the program.

Finally, the Commission will review recent changes to the peer review organizations' scope of work and look at new programs like the payment error prevention program, and consider these developments in the context of previous work and previous responsibilities of the PROs.

DR. WILENSKY: Thank you very much. I think that was a good reflection of where we ended up.

In discussing the issues of quality of care there were several areas that we thought were important but have decided not to focus on, primarily because we feel that there are other groups that are concentrating on these issues and that they are not really our relative specialty of area. I wanted to mention a couple so that you not think that we didn't think they were equally important, but just decided that our value-added contribution ought to be focused in the areas where we had worked and where we believe there is not adequate work going on that we're aware of. That includes issues like evidence-based medicine, and looking at disease management, and case management, and some other issues of that nature.

There were, particularly in this area, a number of places where there was strong interest and a belief that there were areas that were very important that we are not focusing on, although it may come up in passing in terms of some of our reports. But it really was on trying to focus where we had some comparative advantage relative to other groups.

DR. LAVE: I just wanted to mention another area that we had explicitly discussed and decided not to work on, only because one of the commissioners is not here and he probably would have spoken to this. That is the area of the beneficiaries' role in ensuring health and quality of care; another area that we thought was extraordinarily important but that we were not the group to put a lot of emphasis on that unless it came to specific payment issues, making available maybe certain types of benefits, at which point we would address the issue again.

MS. RAPHAEL: I think another issue that we thought was a challenge in this area and really cuts across others is how to get more timely data, and how to get data that would still be credible and valid although more timely.

DR. WILENSKY: When we get to the discussion on hospitals I think this -- we are still struggling with this issue and it's an area where, Jack can review our thinking to date, but it is one where all of us are concerned that we know that we're in the midst of a lot of change. I think Janet mentioned that we are interested in making some assessments of the effects of the Balanced Budget Act. I think everybody in this room probably is interested in having a better assessment of the Balanced Budget Act.

We are all struggling under the problems posed by untimely data. It's an issue that is causing great frustration to members of Congress. They are being pressed to make changes in the Balanced Budget Act. They have asked MedPAC, commissioners and staff for advice. We are able to provide an assessment with the limited information that we have available, but we are frequently working with pre-BBA information and data and very limited post-BBA data. So this is an issue that we will take up, but it has come up in this area in terms of access and impact on seniors, and it has come up in all the other areas.

DR. WAKEFIELD: Beth, if I could just ask you a quick question. Can you remind me whether or not health data and information systems, that particular focus, does the scope of work around that issue include an assessment of the burden of compliance with data requirements? Pardon me if you stated it and I missed it.

MS. DOCTEUR: I think so, particularly to the extent that we can look at data requirements for, for example, Medicaid or other programs and see to the extent to which those are comparable or not comparable, and the extent to which there's duplicative requirements that might be alleviated in some way through better standardization.

DR. WILENSKY: Thank you. Any additional comments?

Scott?

MR. HARRISON: In the area of post-acute care there were a few cross-site issues that you were going to look at. One is to begin looking at how to set up update systems. Previously, the Commission hasn't had to think about them because they've been cost-based systems. Now that they've moved to PPS we want to look and see how such frameworks might compare to the hospitals, how they fit within the hospital framework, and to think about the differences between the types of services and the payment systems and figure out how we're going to want to approach updates.

We also plan on building a database to look at patterns of services across the different sites of post-acute care, sort of episode type files, and that can be useful on several fronts. One of the fronts that we might use it for would be to start looking at perhaps how bundling post-acute care might work.

Another theme that came up was looking at what HCFA's efforts will be on monitoring the use of post-acute care. Again, this is a data problem where it takes so long for the utilization data to come in. We want to look and see if HCFA has got ways of making it come in faster and having perhaps ways of looking at it other than just utilization data.

Moving to some of the specific sectors. In skilled nursing facilities, obviously there's been a lot of discussion about the PPS system this year. We expect that we'd revisit that. There's been congressional interest in looking at the effects that the system has had, and we've made past recommendations that perhaps the case mix might need to be adjusted.

In the rehab facilities area we're expecting a Secretary's rule proposal for PPS to come out in winter or spring. Depending on the timing of that, if we could get our comments on that into the March report we would, but it's possible that it will extend past that.

In October we're expecting the Secretary's proposal for home health PPS and we would be commenting on that. Depending on how that process goes we may or may not invest any more resources in looking at what's happened under the IPS.

DR. WILENSKY: We can indicate we had some skepticism about whether this rule was going to show up on time, although as late as the end of last week we were assured by HCFA that it indeed was going to be there on time.

MR. HARRISON: In long term hospitals we're also expecting a rule in October and we would expect to respond to that.

Then perhaps the last wild card would be the outpatient therapy caps. We suspect that there could possibly be some congressional action. If there is, we would look at that. If there isn't, then we might also do some work on evaluating therapy caps.

DR. WILENSKY: I don't know whether any of the commissioners would like to comment. This area, as Scott indicated, was one of the ones, in addition to the hospital discussion, where we focused the most time and attention on the cross-cutting issues because of our concern that similar services are sometimes provided across different sites. They have very different payment rules associated with those sites, and some of the problems that might arise when you pay for similar services differently according to the site where they occur.

It's an issue that we've raised in principle for the last two years, and we're hoping we can begin to try to develop some framework about how to think about these issues so that we can have some operational results in terms of how we would reduce that inconsistency.

DR. ROSS: I just want to follow up on that general statement. You can view our post-acute care work as sort of fitting into two streams. There's a mandatory stream where we're going to be somewhat reactive, given that the Secretary has a whole list of reports in her lap at the moment that are supposed to be coming out over the next year, and we will react to each of those in turn as we're mandated to do.

Then in thinking about payment updates, but in fact sort of the larger question is how ought we to pay for post-acute care? That's the discretionary work that MedPAC is going to be pursuing, that will feed off the episode database that we're going to create and think about even in the short run how do we update payment rates and follow up from there.

So the discretionary work, if you will, that we're doing is this broader question of payment across settings, and the mandatory kinds of work that we have to do will be reacting to events as they develop from HCFA.

DR. WILENSKY: Thank you.

Jack?

MR. ASHBY: Let me say first that our work in the hospital area also has two primary thrusts, and one is looking at Medicare inpatient payment policies, and second is assessment of hospital financial performance. In that latter area, of course, we do, by all means, need to go beyond the inpatient sector. Ideally, we would consider financial performance relative to all of the services that are provided under the Medicare program, but this would primarily be for outpatient, home health, and SNF, along with the inpatient services.

I'd like to just go over a half dozen or so of the primary areas that we will be focusing on this year. The first one, which Gail has already introduced, is the update. We thought that this would be the year to take a critical look at the model we have been using for crafting our inpatient update.

That issue begins with the one that Gail mentions, and that is that on the physician side we have the SGR. We have nothing along those lines on the hospital inpatient side or in any other sectors. That's really an issue of have we view the SGR. If it's an indicator of what society can afford it may very well be applicable to other services.

We have tended to think thus far that it's more in terms of a signal, if you will, of whether volume is too high or too low. In that respect, it may be less applicable to the inpatient side in the sense that the criteria governing medical necessity are a little more concrete. But we will think through that.

But the update issue goes well beyond that issue. We have had a lot of difficulty, I think we all have to acknowledge, with the update model that we've been using. While on the one hand the eight factors in that model are all highly relevant, cost-influencing factors, but we do have difficulty in the sense that some of them, particularly the productivity factor that we had such discussion about the last couple of years, are very difficult to measure, and also the fact that there's overlap with each other. So we may want to rethink how we're doing that.

There's also the continuing interest in the site of care substitution issue, which has been a major driver of both hospital costs and payments in recent years. We will be doing some episode-based analysis to get at that issue. But we might also consider the possibility of rebasing payments as a way to deal with this outside of the update framework.

But even that doesn't go to the end of the issues, because of course, in today's environment that bumps against another concern, and that is basically affordability. Given the payment provisions that have gone into effect for hospital outpatient, home health, and SNF services one might right away question whether this is the time for rebasing.

But that does suggest another possible strategy I think the Commission will be taking a hard look at, and that's the possibility of some cross-cutting payment adjustments. The obvious relationship is between inpatient and outpatient services where our inpatient margin has reached 17 percent for 1997 while the outpatient margin is or is soon to be below minus 20 percent. So some relative adjustment might be considered.

You could say the same about home health and SNF issues except that there is the obvious complication there that we have both hospital-based and independent facilities, so it's a little bit difficult to narrow in on the hospital services alone.

Then following this is the expanded transfer policy. That will be an issue that we will focus on this year. We have the prospect of expanding that policy from the 10 DRGs that it was originally designed for to all DRGs. We will want to look at that possibility.

But we really also simply want to frame the issue here and consider the advantages and disadvantages of the transfer policy in terms of site of care substitution relative to the update. Those two strategies for dealing with the issue have very different distributional impacts, in addition to payment adequacy impacts, and we're going to want to take a hard look at that.

Then there is capital. We expect capital payments to have a little bit higher profile this year because we are in the tenth year of a transition towards prospective payment on the capital side. When we have fully prospective rates for both operating and capital payments we will want to take a look at how payments ought to be coordinated, particularly with respect to the possibility of a unified update recommendation.

In the disproportionate share area, as everyone knows, the Commission the last two years has made a set of recommendations for restructuring the disproportionate share adjustment. So the heavy work is done here, but we are expecting the Secretary to report out this year on their recommendations for the disproportionate share and we will comment on that.

But we also are doing an analysis that looks at DSH funding; funding for the proposal that we have already put on the table. The key issue here is that we felt that the same payment formula should apply to all PPS hospitals, whereas in the past there was a much higher standard for eligibility for rural and also small, below 100-bed urban hospitals.

When one does that, applies the same formula, it would indeed bring about a rather substantial shift of disproportionate share monies from urban to rural hospitals. In light of all of the other BBA provisions and the like, there's some question of whether that's realistic for large, urban hospitals. So there's the possibility of bringing in new money to fund the expansion into rural areas. There's the possibility of evening out the distribution so that it's not all taken away from urban DSH hospitals but perhaps from all hospitals. So we'll look at some options there.

Then there's the area of the impact of BBA. Our main thrust here will be to expand the inpatient margins work that we have done for a number of years to fill out the other components of Medicare services. We would like to see our margin expanded to have six components: inpatient, outpatient, the excluded units, home health, SNF, and bad debts, which come into play for the first time this year.

This will be a cost report-based margin, of course and it will give us the capacity to continue to look at the individual policy areas, but also to sweep them together and look at the combined impact of BBA provisions on payments Medicare makes to hospitals.

We're going to have light emphasis, if you will, on forecasting out to 2002. That's a very iffy proposition, but we certainly will want to focus in on the impact of the first year of BBA, FY '98, and with claims-based analysis for perhaps the first six months of FY '99.

Then one last area of emphasis. We have recently awarded a contract to Chips Consulting of Columbia, Maryland to expand the payers' analysis work that we have been doing for a number of years. This is basically -- the goal here is two-fold. First of all, let me back up and say that our payers' analysis in the past has looked at payments relative to the costliest of care for the various payers, primarily Medicare, Medicaid, and the private sector.

The difficulty in the hospital arena here is that each of those payer-specific numbers is an amalgam of the inpatient, outpatient, home health, and SNF services, and given the mix changes over time, it's difficult to analyze those results. And they have further been complicated by the fact that we have an unknown mix of fee-for-service and managed care payments, particularly in our Medicaid column, but also in the private sector column.

So for the hospital work we are looking to break those out and be able to, for the first time, have information to compare relative payments between managed care and fee-for-service and between and among the three payer groups.

We are also going to attempt to extend the model to independent home health agencies and independent skilled nursing facilities, and also physician practices, or from a practical perspective, probably group practices. That will be the only organizations able to provide the data.

Much of the study though has a feasibility study feel about it. We're not really sure exactly what it will prove possible to do, but we will attempt to apply the full model in each of these sectors and we will take it as far as we feel that we can generate reasonable data. When we reach a point where it looks infeasible, we will stop in that sector.

DR. WILENSKY: I want to make sure there are a couple of areas that the public is aware that we're going to focus on within this broad array that Jack outlined, because I think they will have some clear, overarching significance to the work we've done in the past.

The first is, as Jack mentioned early on, we're going to use this year as a particularly appropriate time to step back and rethink how we have looked at hospital financial status. We're doing it because the work we do now for the Congress in recommending updates has changed because of the fact that it is in statute. So that our role has been to assess whether the BBA rate of increase appears appropriate. We will continue to do that as we have done this year.

But given that the focus of our efforts have changed in the five-year period, the first five years of BBA, and because there is so much change going on, and because the outpatient is now moving to prospective payment, it seemed particularly appropriate to rethink whether the framework that we have been using in recommending updates is the best framework for the future. We may end up saying that, yes, this is the best framework to try to parse out the individual factors.

But there is a lot of concern, as Jack indicated, that focusing on inpatient margins when outpatient margins may be very different, and where some hospitals will have involvement with nursing homes and home health and others do not, may have too much of a silo effect to give us the best guidance for what makes sense in terms of update factors.

Not that we are looking at this as being margin driven, but the recognition that what is going on in terms of the impact of the Balanced Budget Act changes and other areas in the health care environment will have an effect on whether or not seniors are able to continue receiving services from the hospitals and the hospital-related facilities. We need to have the best way we can to look at the effects of Medicare as opposed to other changes going on in the health care environment.

So this will be a different kind of effort than we have engaged in the past. But we will do it simultaneously with having some of the very specific recommendations, whatever framework we use to arrive there, also available to the Congress.

I'm going to see whether anyone would like to offer any comments. But Jack, I'd also like you to walk us through some of the discussion we had yesterday about how to try to get timely data. I think it's important for people to understand what the problem is. That there has been, in the past, some length of time between when events occur and when we get data. There is a particular problem now because some of the past datasets are no longer available. There's some hope for the future because of some new activities going on.

And then there's an interest in the Commission about seeing whether we can jump-start some kind of early indicator or projection basis, subject to refinement and reconciliation when audited numbers are available. This is something I think the commissioners felt strongly about, but I think it's also important that we have this as part of the public discussion.

MR. ASHBY: Okay. The basic problem here for the hospital arena specifically is that the two primary datasets that have driven our analytical work over the years, the Medicare cost reports and the AHA annual survey, are both on a roughly two-year turnaround cycle. And the way things have been moving in the last couple of years, two years just seems like a longer period than ever.

We have found ourselves this year where we're generating 1997 data that show a financial performance peak, if you will, at the very time that everyone's talking about the impact of the BBA and we are left with two entirely different pictures, and we don't want to contribute to that problem.

But we also in the past have made major use of the AHA panel survey, which was a monthly survey that had about a four-month turnaround. Four months is a terrific opportunity to look at recent trends and we made great use of that, both in terms of general monitoring and as part of some of our analyses supporting the update.

The AHA made the decision this last year to stop the panel survey, and they have plans to replace it with a differently-structured survey that I have to say I think has great possibilities for the future. This would be a combined effort of the AHA and the Colorado Hospital Association. The system is known as Databank and when fully implemented, first of all, it will not be on a sample basis. It is organized around state hospitals, administered through state hospital associations. So we will end up with a sample of states as opposed to a sample of individual hospitals.

But since the states are coming on rapidly we can foresee the point two, three, four years down the line when most of the states are participating and we will view it as close to a universe dataset that would be very useful. It also has payer-specific information in it which the panel survey did not in the past and that represents a significant improvement.

So basically, we could reach the point years down the line where we have perhaps even less than a four-month turnaround, perhaps as small as a two-month turnaround, because this is a web-based system -- could have on as small as a two-month turnaround all of the payer-specific information that we had had previously from the annual survey on a two-year turnaround. So I think there are lots of good possibilities there.

The problem is that in the short run we, at the moment, have nothing. And this is a critical year to go into our decision-making in the fall and winter with no information on what's happening in 1999, a very critical year and relatively little information in what happened in 1998.

So the Commission was interested in the possibility of we, the Commission, and possibly the Health Care Financing Administration as well, and possibly jointly with the AHA, doing something at least as a transition work for the next year, two years, three years. It's unclear how long it would take -- that would recreate the kind of information that we used to get from the panel survey. There are a set of 2,000 hospitals out there for one thing that are used to this regularly reporting and it might be possible to put something together that would at least tide us over.

And we would hold open the question how long it needs to go on and whether it needs to continue indefinitely and in parallel. Hopefully, the answer would be no, that we would sooner or later reach the point where we have a system we're all comfortable with. But we would just simply hold that in abeyance. So we're going to be looking into that in the near future.

To be helpful, that needs to be a this-year activity. It can't be something that takes a year to get organized. That would defeat the purpose.

DR. WILENSKY: I just want to emphasize the sense of urgency that I have felt as a result of some of the discussion I had in the Finance Committee hearing and exchange last week, and other discussions I've had with representatives of the hospital industry, and I know other commissioners as well, that we need to find an interim way to know where we're going.

In the end, many of the decisions may well be made on a political basis, but it is unfortunate to not be able to see the effects of legislation and be able to at least make recommendations based on the empirical changes that are going on right now. So we are going to try to have a change in place, if we can figure out how to do that, working with HCFA and anyone else to try to get us through this transition period so that we can make more timely recommendations. Understanding that it will not be perfect data, but better than having two-year-old data.

DR. LAVE: This is on a different topic but it's related to hospital payment.

DR. KEMPER: Before you do that, I just wanted to underscore what's been implicit here that while the AHA data collection change is particularly to hospitals, this issue of timely data is not unique to hospitals. It's across the board in almost every area, where we'd like to know more about what's happening as a result of the BBA but don't.

DR. WILENSKY: And the issue with regard to home care and skilled nursing facilities has gotten a lot of press lately and there are at least the problems of data. Sometimes there's additional problems of not having clinical information about the patients that are being served, or detailed information about the services that are being provided that complicate it even more so.

One of the reasons that we are focusing on the hospital area even more than the others -- but Peter is correct, our concern is across the board -- is the fact that it represents a lot of money, and also that the work has progressed a little farther in this area in terms of the data collection issues. So we're hoping that it may be possible to jump-start this first. But we are as concerned about home care and skilled nursing facilities and other post-acute and other areas of Medicare.

MR. ASHBY: Let me just comment that if the contract that we're talking about works out the way that we hope that it will, we will have better information for independent SNFs and home healths than we've had in the past two for 1998. But that's still not the level of timely data that I know you would really like us to have, but it would be a step forward.

DR. LAVE: I just wanted to point out that there actually is a large initiative in hospital payment that Jack did not talk about, and that is related to the work on refining the DRGs and refining the system that is used to assign the weight to those DRGs. It's important, I think, overall for hospital payment and it is something that the predecessor commission was working on and the current commission is taking up.

This is a segue into the next topic. It is also important, and in conjunction with some of the recommendations that we're making on GME, but it is not necessarily tied to the GME work.

DR. WILENSKY: Any other comments that people would like to make on this discussion area?

We'll see how it actually turns out. I think it is a very exciting array of issues, in part because it's stepping back and relooking at ways that we have done things which is appropriate and healthy to do from time to time. So we'll look forward to seeing how this progresses during the year.

We're going to turn to graduate medical education, but before we do that I'd like to offer this as a public comment period if anyone has any comment about the work we have outlined for the other areas.

MR. CALLEN: Mark Callen, Health Care Association of New York State. With all of the efforts related to data I just wanted to suggest that with the Administrative Simplification Act that was passed by Congress a few years ago there's going to be some substantial changes coming up over the next few years, new provider IDs, payer IDs, electronic standards for submission of claims. I think that it would be worthwhile for MedPAC to just stay abreast of either potential disruptions in the flow and access of data, but also potential opportunities in perhaps once this is all done, greater availability, greater accessibility of data.

Secondly, I would just like to respectfully suggest that in your expansion of your examination of the BBA impact on the various areas within the hospitals and your margins analysis that you also include graduate medical education as an area that you look at payments and costs.

DR. WILENSKY: Thank you. The reason, I assumed obviously that we have not heard it is that we were saving that for the last session because we have a report due in August. Comment has been made that in our recent reports we have been silent on graduate medical education. I would have thought I had made this comment enough times that it would sound like a broken record, but let me make it again.

The reason there was not a chapter on graduate medical education in our March report or in our June report is because we have been directed to produce an August report to the Congress on graduate medical education, and we were not prejudging where we would be in that area. That is where we are going to turn now to our discussion on some of the principles and the review of where we have been in terms of premises and assumptions and a look at how to go forward with this in order to get us ready for our August report.

MR. LISK: Thank you. As the Commission discussed over some past meetings and also yesterday, the Commission's approach is based on a set of principles about program policies and premises about how our world works in our market economy. There are basically three areas within the graduate medical education report that the Commission is looking at in terms of what Congress asked us to look at.

One is basically payment policies, and more specifically Medicare payment policies.

Others include workforce, and even more specifically for this commission is what should Medicare policy play in the workforce arena?

Then a third area is what's due -- about the financing of other socially useful activities that teaching hospitals are involved with, and other providers in the education system are involved with, such as research and development and provided uncompensated care as examples of those.

What I want to go over now though is also the overriding principle in terms of the number one principle that the Commission discussed, is Medicare policies should promote access to high quality care for Medicare beneficiaries. This was a principle that was part of Chapter 1 in the Commission's March report.

Now when we think about the GME arena there are three premises. And premises are sort of facts that the Commission has discussed. One is the cost of training is borne by the resident in the form of lower wages. A second is that costs are in fact higher in teaching hospitals. And third is that the costs are higher because the care in teaching hospitals incorporate product differences that add value for Medicare beneficiaries.

I'm sorry, I skipped over one of the other principles that comes after the first overriding principle, and that's Medicare payment should be consistent with an efficient provider's marginal cost for producing high quality care. Again, that is setting the stage for how we look at GME.

But as I talked about those three premises we lead to a third principle, and it could also be considered a possible recommendation. That is, patient care payments should reflect product differences of value to Medicare beneficiaries in the settings where residents and other training takes place.

The type of product differences we talk about here include, in terms of the involvement of residents in patient care delivery, is the greater oversight and review of patient care in those settings, is one example, the more advanced technology being produced in teaching hospitals and other settings, and the more advanced procedures that might be conducted there.

There's also an aspect that's more of the characteristics of the patients in those settings too that we have to take account for, and that's the greater severity of patients that may be seen in some of these settings.

A fourth principle that we discussed though is also the broad social problems related to access to care cannot and should not be necessarily addressed by Medicare. Some examples of these would include, in terms of supply of facilities or supply of practitioners in a particular area, for instance. It's not specifically a Medicare issue. It may be considered a broader federal government issue, but not a Medicare payment policy issue.

This leads to another principle that the Commission discussed, and that really means -- taking these into account really means that workforce policies generally should be separate from Medicare patient care payment policies.

This also leads though to, in thinking about Medicare's own payment system, that Medicare though should not provide financial incentives for training of residents. If we think about this too then, in terms of how Medicare policies are involved in this whole system, is that Medicare payment policies should seek to avoid creating market distortions that inappropriately affect health care workforce. That includes the supply, the mix, and the geographic distribution of practitioners.

So when we think about Medicare payment policy as well as a part of that, we can think of another principle which is that the influence of resident counts in determining hospital payments should be reduced. That may also be considered as, in part, a recommendation.

But in terms of how the current Medicare payment system works, we're paying based on basically resident counts in some way. So there is an inherent incentive potentially there for hospitals to have as many residents as they want. Now there are caps now in place that put an upper bound on that, but the current payment system still encourages hospitals to have as many as they can have potentially up to the cap if you pay based on per-resident amounts.

Recognizing all this too though, in terms of how payment policy might change with recommendations the Commission might make and if there would be major distributive effects, there's another principle that if possible should not have major shifts in Medicare payment rates from one year to the next. So that is a principle of transition in these payment policies.

Finally, on the level of principles, and this is one also that the Commission discussed that they thought should be up front in a way, is that a recognition -- actually, this is a fourth premise -- is that a competitive market will not adequately support certain types of activities provided by teaching hospitals and other hospitals and even other types of facilities, such as uncompensated care, and research and development for new technologies, the introduction of new surgical techniques and those types of things.

So that's the basic discussion in terms of the overarching principles and premises that the Commission discussed, and that leads to some potential consideration of recommendations. I don't know if you want to stop there.

DR. WILENSKY: Let me try to set the stage, because I think it's important that the commissioners want to talk about some of the issues. Let me try to summarize as I have heard both as you have restated it and what's gone on in these past meetings.

What we have been struggling with, which those of you who have followed these discussions have struggled with us, is how to try to set a framework for thinking about these issues. And where we have come down is on a couple of ways to view what it is we're trying to do and to differentiate the role that Medicare as a specific program financing services for seniors ought to take as opposed to other roles that may be appropriate for the federal government or for government as a whole but that don't relate to the fundamental role of Medicare, which is to finance high quality services for seniors.

Within that context, to think about those issues which we thought were fundamentally germane to making sure that seniors have access to these high quality services and other issues that are perfectly appropriate topics for discussion because they may be public goods, because they may impact issues that the government or the Congress has indicated are important, but that we don't distinguish as being appropriate to the Medicare program per se.

What we focused on is the issue that there are observable cost differences in providing health care services to certain individuals, particularly those associated with training and education, and that we believe, although we have discussed some of the difficulties of actually trying to quantify some of these differences, that they are not just cost differences, but they are cost differences associated with having a service that the Congress has indicated is important that seniors not get shut off from and that we also believe provide some real value added in terms of the kind of services that are available.

That means if seniors are going to have these type of services available, we have to make some kind of compensating payment differences, otherwise the fact is they are not likely to have them available. It's within that context that we've tried to think about making payments that compensate for the differences that having some of these training programs available, either as training or as education or some combination, make on providing these services available and to think about the payment within that concept rather than try to distinguish the various concepts that have been raised in the past.

To the extent that we are comfortable thinking about this as a framework and to say there are other issues like some workforce issues that are legitimate areas for the federal government to think about but that are not directly germane to the Medicare program insofar as that affects the accessibility of high quality services for seniors, that those are issues that ought to be dealt with by the federal government to the extent the federal government regards it as important, and in fact recognizing that there actually are places already designated to deal with such issues such as the Bureau of Health Manpower, COGME, as a specific commission, et cetera.

To focus on both the philosophy, and then to talk about how one would actually go about estimating what this would mean in terms of payments. Then also talking about what do we mean in terms of the distribution of payments. And as I've recalled some of our discussions, to recognize sometimes it's because we haven't done a very good job, or as good a job as we would like to do in recognizing the cost of providing services to people who show up in academic institutions.

So we have talked about, and I think it's already come up in Jack's discussion of hospitals -- I guess Judy raised this point -- that part of what we would like to see happen is that we would have greater direct recognition that severity of illness appears -- we think is greater in academic health centers. At least it is conventional wisdom that it is greater in academic health centers. And that we would be able to do a better job if we can refine the DRG system so that we better measure differences in severity of illness rather than try to find some auxiliary type of payment system that more or less proxies these differences.

So as part of our work on understanding that if we don't differentiate the payment system very well we will not be able to fulfill the primary mission of making sure that seniors have access to high quality health care, that we're going to try to push forward on this other front.

So to do things that we may have looked to other payments, like graduate medical education or other special payments, to see whether we can't make the primary payment system better than it has been in the past, but to continue focusing on this notion of trying to compensate for different cost structures that are also associated with value added or high value services, and to use that to try to move us forward both in setting up the general principles for a series of recommendations about how this would affect payments to teaching institutions, wherever they be.

Inpatient has obviously been the focus on attention in the past but this is a principle that certainly extends beyond an inpatient hospital setting. And to think about what it would take empirically to try to measure what these differences are and then to begin operationally implementing such a system for change.

This commission and its two predecessors commissions have been very sensitive to the impact of change on institutions and individual providers. So although we will deal with this when we actually look at specific recommendations which we'll discuss in some detail in our July setting, we have already discussed the fact that whatever we're talking about, we will look at phase-ins and how to basically move from where we are to another system.

But my sense as we have tried to bring our new commissioners into this discussion is that we are continuing to feel comfortable that thinking about payments in this framework is a way that we can move forward and find consensus recommendations to make to the Congress about those things that we think are Medicare-specific, those things that we think are appropriate areas for the federal government to consider but not Medicare-specific, and how to think about the payments primarily as reflecting cost differences associated with value-added services or high value services that if they are not compensated for are unlikely to be available to the public.

So my sense is that we are continuing down that path and that having had a chance to bring out new commissioners into this discussion, which certainly took us a long time as the older commissioners to get there, that we are continuing on this track.

With that, let me see whether I can open up discussion if people want to make any further comments. This will be the primary, if not the entire focus of our July meeting. How to try to get from these framework principles, assessments, to looking at specific wordings of recommendations and text around the recommendations and be able to be sure we really understand exactly what's going on in terms of this way of looking at that.

DR. NEWHOUSE: I might take this chance to respond to a letter we received from the American Academy of Family Physicians that I think reflects a misconception, and because other people may share this I think it's worth saying something.

As Craig and Gail said, we are of the view that the resident bears the cost of training in the form of a lower salary or wage, and therefore the higher cost of teaching institutions that appear on the Medicare cost report are not reflecting the cost of training, or not attributable to training. Now the academy says, in this view that education is viewed merely as a byproduct of the resident's patient care responsibilities, and goes on to say, we do not believe that education is a free byproduct of services.

Well, we don't believe that either. For example, it would be how to think of how a director of graduate medical education's salary could be anything other than a cost of training. We just believe that that cost is, in effect, covered by the difference between what the value of services is that the residents provide and what the resident is paid, and therefore, does not show up as a higher cost on the cost report. It's a matter of accounting.

In fact, the academy goes on to say something that the Commission --

DR. WILENSKY: Which academy?

DR. NEWHOUSE: The Academy of Family Physicians goes on to say something we agree with, which is they say, in their view, we need policies that separate the needs of Medicare beneficiaries for services from the needs of the country for a superb physician workforce. I think that's where we also have come out.

DR. WILENSKY: Again, we have tried to differentiate that there are issues with regard to workforce and distribution that the government from time to time has tried to deal with and we are not making -- at this point at least we are not planning on making specific recommendations as to how the government ought to think about this, but to make clear that there are either existing or could be new entities appointed to specifically look at these issues.

What we think is very important for this commission and for Medicare to do is to make sure that there are payments recognizing cost differences associated with services that we want to make sure are available to our senior population and that we structure a set of payments recognizing that there appear to be measurable cost differences that we think are associated with a differential service. And that that will lead us to try to go ahead and describe how we would estimate what these payments should be and what it would suggest about the distribution.

Obviously, there is some question as to how far we will be able to get in terms of August of a directive of specifically how you would make this payment estimation. But to the extent that we continue to be comfortable, can come up with a series of specific recommendations relating to this following our July meeting and subject to an August report, we will continue down that path so that in the fall or as part of our ongoing March payment reports we will now be able to say, given how we have laid out the framework for looking at this and the recommendations about what we would do, these are the kind of payment changes that would appear to be appropriate given the model for making these changes.

We have identified -- again, I want to assure people that it has been part of our discussions, although we have not gotten in any way specific, that we would have some type of phase-in or transition period. We can decide how much attention we as commissioners want to give as to the alternative ways to have phase-ins or whether or not we just want to make that an important part of what we would state for the changes.

We will, obviously, have a lot of discussion about the specific recommendations that we are thinking about including, but at least for those of you who have been following these discussions, we are continuing down the path, we're refining our thinking a little in terms of what it means that we should be worrying about and what it means that we ought to say is an important issue but not a Medicare-specific issue.

DR. WAKEFIELD: Just a couple of quick comments. I'd like to reiterate a couple of the points that I made yesterday related to this topic and then I'll personally, as a new commissioner probably be struggling through between now and July and then at the July meeting as well. Everyone else or most other people around the table are much better immersed in this than I am, having had the benefit of having discussed this for a longer period of time.

But I guess a couple of the points I'd want to make, Craig, is when you were talking about this and as we discussed it yesterday, the criteria that I think we're starting to coalesce around that need to be met are, number one, that there must be measurably different costs, and that secondly, there are important differentiated products that are provided as a result of that patient care. The term applied might be better, but that is that the care is better or that it might be higher quality, or whatever the term is that's in play.

You might recall yesterday -- and so I'll still be interested in this July -- that I was wondering then how those criteria -- and then as a result, those two criteria met, obviously a payment adjustment would then be considered. So that seems to me to be the overarching framework.

One of the questions, and I would assume we'll be discussing it further in July is, how do those criteria play out in primary care settings, for example. You talked a lot yesterday about teaching hospitals. But just to sort of put my placeholder in there, I'm also very interested in knowing what the application of these principles might be in non-teaching settings. That is places where teaching occurs not just within teaching hospitals. That was one comment.

Secondly, we had very little, because I think we ran out of time, very little discussion about what that framework might mean for non-physician training, which is part of GME right now. That was sort of an asterisk because I think we ran out of time. But again, I would assume either this commission has already had a full discussion of that or that we will be in terms of how that gets filtered through these criteria. I'd be interested in that discussion as well.

Then the last point for me is, as you started the -- I think they were principles as you pitched them. I don't have it right in front of me, and it might have been one of the first principles that we had discussed yesterday was the notion of Medicare policy should promote access to quality care for Medicare beneficiaries. That's sort of an overarching goal.

Probably again as a new commissioner, I see the quality care enveloped in that, and that context that I ticked off just a minute ago, it's that access part that I'm personally still struggling with and I'll look for a discussion around that as we go on. That is, I realize what we're saying about workforce issues, that we're setting those issues over here. But I still have concerns about access to quality care, maybe in my own orientation to that concept of accessing high quality care and services, probably especially because of my particular interest in rural health care.

I just want to reiterate some of those key issues -- they were key to me anyway -- that I've raised over the last couple of days and put them back out on the table, to say that I would assume that I'll be thinking more about it and we'll be discussing some of these issues a little bit more in July.

DR. WILENSKY: Let me just respond to something that you raised, because again, it may be in other people's minds as well. We have as a major charge, and something which we take seriously, looking at access for seniors. So this is a general area of concern. Every report for the period I've been associated with either PPRC or MedPAC has included a section, and I'm confident in all of the other reports with which I was not involved also had sections on access.

We look at issues with regard to access, and hot spots, and problems, and to the extent that there are specific acts of either commission or omission by Medicare and exacerbate those issues that are Medicare specific, we try to make some comment about what Medicare could be doing that would ameliorate or change access problems as we know them.

Within the GME world what we've been recognizing is that to the extent that some facilities have higher known costs because of education and training --

DR. NEWHOUSE: Or some associated with that.

DR. WILENSKY: Or something associated with that, that if we don't make some corresponding adjustment to the payment we will effectively reduce or shut out access to those types of institutions.

So we are not trying to think about GME as a mechanism for ameliorating all access problems. But rather, recognizing that to the extent that institutions engaging in this have higher costs, that we need to recognize that in the payment.

That isn't to say that we aren't going to be concerned about other access issues, although we may have, as we have in some earlier PPRC reports, come to the conclusion that where we note problems of access in the so-called hot spots areas, some very selected places, in the past they have appeared to be general problems about access to health facilities and personnel period, in general, and not a reflection of a Medicare-specific problem, which to our mind has raised the issue that this is not something that Medicare per se is likely to be able to resolve. It's a broader issue to the extent that the Congress or the government is willing to take this on as an issue, or at least to recognize that this is not a Medicare-specific access problem. It may be a general access problem and that can lead to a series of steps.

So we're into the issue of access to the extent there's a reflected cost difference that if we don't acknowledge is likely to lead to an access problem. And we're just going to try to separate that because we deal with these other issues separately. So it's important to make sure we don't forget about raising the other issue. But I think it's equally important that we not put too much on the back of what is already, for us has been a complicated issue to deal with.

But again, we will be discussing this in great detail. We're going to try to see whether this framework helps us. We think thinking about the issue in the way we just described will allow us as a commission to make recommendations about changes that seem appropriate. We'll know for sure when we are facing wording for recommendations and to see whether or not people continue to have comfort, and with the discussion that goes around it. Because again, right now we're only likely to be able to get so far down the line as to specifically what this would suggest with regard to payment changes.

But to the extent we continue to be comfortable, we expect to see changes in the March report, or recommendations for payment changes to start being introduced or phased in that would be consistent with the recommendations and principles of our August report. So it's not going to be the last word by any means, but it will be a different set of recommendations in further reports then if we don't continue down the direction that we're now going.

I think it was useful -- I'm encouraged. I have felt this for the last couple of meetings, that there appears to be developing consensus going down a particular strategy. Again we'll know for sure when we actually start working on the language and recommendations.

MR. LISK: Did you want to me to, in terms of your thoughts in terms of the primary care settings?

DR. WAKEFIELD: Sure, if you will.

MR. LISK: It really is -- the two criteria that we talk about is higher cost and a different product. So if we establish that that's occurring in that setting -- and you may interpret in terms of the extra time because the residents involved with the patient care has more contact with a physician in some sense, or that there's really two people being involved, you may consider that -- and some of that's going to be interpretation in terms of whether that is a different product or not.

But if you interpret that as a different product that you feel is worth paying for, that adds value to the patient care, in that case then it will be recognized in those settings, if the costs are higher. Now it has to meet both -- both criteria needs to be made. The same applies for when we talked about non-physician health care personnel. It's the same type of principles are applying here.

DR. WILENSKY: Right. So again, it's both criteria: that there is a value added that is being provided that we want to make sure people have available, as opposed to just a cost differential. That's not enough. There has to be both a measurable cost differential and something that we think is important that gets paid for that's being provided in those sites that will then lead us to try to establish what would be an appropriate mechanism.

Any further comment?

Let me open this up to any comments from the public that people wish to make.

[No response.]

DR. WILENSKY: Okay, we will be meeting again July 15th. It will be on our web site precisely where it is and our starting time. Any of you who want to come, plan on being there for a long meeting.

[Whereupon, at 11:23 a.m., meeting was adjourned.]